

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP () IE () IC		Response Timely Filed? (x) Yes () No	
Requestor's Name and Address Valley Center for Pain & Stress Management 5801 N. 10thSt., Ste. 100 McAllen, TX 78504-2601		MDR Tracking No.: M4-04-0769-01	
		TWCC No.:	
		Injured Employee's Name:	
Respondent's Name and Address Travelers Indemnity Co. c/o Travelers Companies		Date of Injury:	
		Employer's Name: Haggar Clothing Co.	
		Insurance Carrier's No.: 482CBBW04867K	

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
11/19/02	01/20/03	97799-CP	\$5,850.00	\$3,900.00

PART III: REQUESTOR'S POSITION SUMMARY

Summary Position states in part, "...At this time, I feel that we have made attempt to resolve this matter with the insurance carrier to avoid this action, but have not been successful. Valley Center for Pain & Stress Management's services were pre-authorized and determined medically necessary to the compensable injury... On August 5, 2003, the response for our 'Request for Reconsideration' was received. I spoke to the adjuster, Val Sloan to see if this matter could be resolved without going thru this process, but she informed me she was not changing their decision. I then spoke to 'Sharon Peebles' the adjuster's supervisor and after reviewing the file returned my call and also stated their decision remained the same..."

PART IV: RESPONDENT'S POSITION SUMMARY

The Respondent did not submit a position summary.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

Disputes M4-04-0769-01 and M4-04-1445-01 have been combined into the M4-04-0769-01 as the additional information was inadvertently docketed as a dispute.

On March 3, 2005 MDR faxed 33 pages of EOBs to Travelers Indemnity requesting payment for these preauthorized services be made as they were denied per RME report. On March 14, 2005 St Paul/Travelers submitted EOB's that showed payment was made for most of the dates of service; those dates of service that remain unpaid are 11/19/02, 12/17/02, 12/18/02, 01/07/03, 01/15/03, 01/17/03, and 01/20/03.

- CPT Code 97799-CP for dates of service 11/19/02, 12/17/02, 12/18/02, 01/07/03, 01/15/03, 01/17/03, and 01/20/03. Original EOBs were not submitted by either party; however, the reconsideration EOB states "Code – O Received faxed reconsideration for dates 10-24-02 thru 01-22-03. Payment still denied per RME report previously sent to provider". Per Rule 133.301(a) a carrier may not retrospectively review the medical necessity of a medical bill for treatments/services which have been preauthorized. Per the 1996 MFG,MGR(II)(G)(9) the Chronic Pain Management program has no MAR and therefore DOP is required. The health care provider submitted convincing evidence that services were rendered as billed. Per Rule 133.1(a)(8)(B) the health care provider did not submit documentation to support that \$150.00 per hour is their usual and customary amount they bill; however, the insurance carrier has paid \$100 per hour for the program; therefore, reimbursement in the amount of \$3,900.00 (39 hrs x \$100/hr) is recommended.

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of \$3,900.00. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

James Schneider

04/11/05

Authorized Signature

Typed Name

Date of Order

Decision by:

Marguerite Foster

04/11/05

Authorized Signature

Typed Name

Date of Decision

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____